RESPONSES TO CMS QUESTIONS, WAIVER APPLICATION 9-30-2002

COST EFFECTIVENESS:

1. Please clarify whether the cost effectiveness calculations include the capitation increase that will occur as a result of the QAAP. If so, please adjust the calculations to reflect cost effectiveness without the increase.

The waiver amendment request originally submitted June 7, 2002, has been withdrawn. This Waiver Renewal package does include a capitation rate increase, which has been appropriated in the state budget. This rate increase is necessary because of increased health care costs generally, and pharmacy costs in particular. Michigan Medicaid health plans have received no rate adjustments since the October 2000, at which time a competitive bid process and contract renewal occurred. The rate increase is necessary to sustain the managed care program and will be further explained and justified as a part of discussing cost effectiveness issues.

2. Please specify what services are included in the category "wraparound services adjustments" for years 3 and 4 in appendix D.IV, Without Waiver Cost Development spreadsheets.

The wraparound services adjustments for years 3 and 4 in the Without Waiver Cost Development spreadsheets are related to pharmacy. Pharmacy is separated from the rest of the fee-for-service providers by locating it in the wraparound section so that the unique aspects of pharmacy (e.g., the very high trend and federal rebate) can be dealt with clearly. The rebate is captured under the column entitled Undifferentiated Adjustments.

3. Please provide a statewide summary of all the adjustments made to the years 3 and 4 without waiver costs, including the associated dollar amounts and the calculations and/or assumptions made.

The requested statewide summary of year 3 and 4 without waiver adjustments has been provided.

4. Please provide assurance that General Medical Education (GME) costs are not included in the without waiver cost development calculations.

Michigan assures CMS that Graduate Medical Education (GME) costs are not included in the without waiver cost development. Please note that GME is absent from the adjustments to claim costs.

5. The cost-effectiveness documentation shows savings under the waiver of about 16% of costs over the two-year renewal period. Please provide additional information on how these

savings will be realized. For example, how do contracting arrangements under the Comprehensive Health Care Program help ensure that costs are lower under the waiver? And how do health plans hold down costs while ensuring beneficiaries' access to care? Please tell us the basic story behind the successes of the waiver program.

This cost effectiveness resubmission results in average savings of slightly more than 9% over the two year renewal period, about 7.2% in year 3 and 10.9% in year 4. No rate increase is included from year 3 to year 4 because there is no indication what the new administration will propose in the next budget in light of the very large budget deficit in Michigan. It does, however, include an 11.88% rate increase to be implemented during FY03 with the result that savings are moderated to the 7.2% figure.

Michigan has not increased capitation rates since October 1, 2000, when the most recent competitive bid was implemented. The comparison to the fee-for-service equivalent (FFSE) benchmark showed a 7.7% savings for FY01. The 7.2% savings in this waiver renewal package for year 3 is almost identical to the savings, which were realized as a result of the competitive bid process. The State is tracking the managed care savings amount, which came out of the bid process with the 11.88% rate increase. That increase is very close to the two-year aggregate trend (the product of price and utilization increases) in without waiver costs.

The competitive bid process enables the market to set rates that reflect the savings which are achievable by the managed care industry. In essence, the State is maintaining consistency with the rates, which were established by the market.

Managed care savings are realized from management processes implemented by the HMO industry in Michigan. These processes include: disease management; professional review of inpatient hospital and other high cost services; selective contracting including the use of formularies for pharmacy; and generally, strategies which emphasize the provision of ambulatory services to prevent more expensive acute episodes.

Since the State has emphasized its managed care strategy, the industry has matured. The cornerstone of the success of the managed care program is health plan accountability for the delivery of quality services and measurable outcomes. The quality oversight system for the Medicaid Health Plans includes the following components:

Reporting: **Plans are required to submit regular reports of service and administrative activity, as outlined in their contract with the state. Required reports include: 1) Health Employer Data Information Set (HEDIS) reports; 2) complaint and grievance activity reports; 3) internal quality improvement activity reports; and, 4) provider network activity and financial reports. The state analyzes reports on an ongoing basis to identify potential problems, and follows up with plans to correct problems. Together with other quality evaluations, these reports identify exemplary practices that the state encourages other plans to replicate. The state's goal is to encourage all plans to adopt "best practices".**

Accreditation: **Health plans are required to be accredited as managed care organizations or apply for accreditation by 10-1-02. The state monitors health plans accreditation status to determine compliance with state requirements. The department also coordinates its Health Maintenance Organization regulatory activities with accreditation.**

Structured On-Site Reviews: **The state performs semi-annual contract oversight and on-site reviews of health plan operations in conjunction with licensure activities. These reviews are used to determine ongoing compliance with contract and licensure requirements.**

Consumer Surveys: ***The*** **state contracts for an independent consumer survey using the Consumer Assessment of Health Plan Survey, a nationally recognized survey tool. The survey includes beneficiaries enrolled in the health plans, Children's Special Health Care Services Program contracted plans, MIChild contracted plans and Medicaid beneficiaries remaining in the Fee For Service Plan. Health plans are expected to use the results of the survey in their quality improvement efforts. Results are used in ongoing monitoring of the health plans, as well as the development of the annual Consumer Guide.**

Performance Measurement Monitoring Standards: **The department has established a set of performance measurement monitoring standards that are integrated into the contract between DCH and plans. The performance standards include measures of childhood immunization; prenatal care; well child visits; complaint and grievance; encounter data reporting; and claims reporting. Health plans that do not meet minimum performance standards must develop corrective action plans. DCH may impose sanctions including financial sanctions as deemed appropriate.**

Public reporting:
A Consumer Guide is developed annually that summarizes health plan performance and customer satisfaction. The Guide is provided to medical beneficiaries to assist in their enrollment decisions

Enrolling the Medicaid population in health plans that are organized to be accountable for improving health outcome measures has resulted in improved access to and the use of preventive health care in the future.

The quality oversight system for the Medicaid Health Plans provides evidence of the continuing improvement in the delivery of health care services for the Medicaid managed care population and demonstrates that accountability and rewarding performance are viable components of the Michigan Medicaid program. To further exemplify and demonstrate a commitment to rewarding performance, MDCH is examining various quality reimbursement structures that reward both quality performance and quality improvement by the plans, with the objective of integrating a quality adjustor into the rate payment structure for FY 04. The structure of the quality-based approach will address necessary cost growth as well as quality performance by the plans.

6. The cost-effectiveness summary table shows spending under the current waiver and expected spending for the two-year renewal period. We used aggregate spending information from this table to calculate the growth rates.

Data for program costs (administrative costs not included)	Growth rate Yr 1 to yr 2	Growth rate Yr 2 to yr 3	Growth rate Yr 3 to yr 4	Growth rate Yr 1 to yr 4
With waiver	-1.1%	13.8%	0.7%	13.4%
Without waiver	- 4.6%	26.8%	5.5 %	27.6%
Difference (higher or lower growth under the waiver)	3.5%	-13%	-4.8%	-14.2%

During the first year of the current period, growth in spending under the waiver was higher than what would have occurred without the waiver. Why is this so?

For the renewal period, the pattern is expected to change so that growth in spending is lower under the waiver than it would have been without the waiver. What accounts for this change? For example, has Michigan changed its program or contracting practices to better control spending for program services under the waiver?

There is a disconnect between the financials for years 2 and 3 which are misleading in terms of drawing conclusions. The rate cell structure in its application of risk adjusters was substantially revised since the last waiver filing. Changes include a maternity case rate, a significant redefinition of regional boundaries, and the use of the DPS as the risk adjustment method for the blind and disabled. Further the managed care population itself has changed to exclude Medicare beneficiaries from managed care.

Our interpretation is that the structure of the waiver filing requires us to represent years 1 and 2 in the old format. The implication of conforming to this structure is that there is a significant misalignment with years 3 and 4 for all of the reasons cited above.

Finally, it should be noted that there is a gap in time between years 2 and 3. The fiscal periods corresponding to years 1 thru 4 are as follows: Year 1 = FYE 6/30/00; Year 2 = FYE 6/30/01; Year 3 = FYE 9/30/03; and Year 4 = FYE 9/30/04.

7. Growth in spending between years 2 and 3 (about 14% under the waiver and 27% without the waiver) appears to be at least partly the result of a significant increase in member months for the time period—108% growth in member months was reported in supporting documentation. This rapid growth is in contrast to falling enrollment between years 1 and 2 of the current waiver.

Please explain the expected growth in enrollment for the first year of the renewal period (that is, between years 2 and 3). We assume only a small part of this growth could be attributed to

expanded coverage under the "rural exception" program. Does Michigan expect enrollment growth attributable to this program? What other factors explain the growth in expected enrollment in the renewal years?

The major explanation for spending growth between years 2 and 3 is provided in the answer to question #6. Of the various elements cited there, probably the most influential as it relates to overall spending growth is the 15-month gap between the years. That has the effect of accentuating trends, especially in the without waiver costs.

The growth in the managed care enrollment can be tied primarily to two factors. The first is that FY01 was a transitional period from the competitive bid where losing health plans had their enrolled population displaced. The need to reenroll these populations with the winning plans in their regions took some time and deflated enrollment totals for the year.

The second factor is simply tied to the growth in Medicaid eligibles, especially in categories which are mandatory for managed care. The Healthy Kids category in particular showed substantial increases in eligibles during this period of time.

8. The cost-effectiveness summary table includes a line titled "budget reduction in appropriations" that shows savings of about $17 million in each of the waiver renewal years. What are these savings? Why are they only shown as savings under the waiver (would not a reduction in appropriations affect without waiver spending as well)?

The $16.8 million budget reduction in appropriations is one of many actions which were taken to address Michigan's budget problems. We have included it under the without waiver spending in this resubmission on the assumption that these same savings would have been taken if these services were being delivered under fee-for-service arrangements.

9. The cost-effectiveness summary table shows administrative costs decreasing by about 31% over the two-year renewal period, compared with the current waiver period. Specific administrative activities show even greater changes, with two of particular note. Spending on medical on-site review is projected to fall from $4.7 million during the current waiver period, to about $2.6 million during the renewal period. Costs for data management, which were about $2.5 million during the current period, are projected to turn into $200,000 in savings during the renewal period.

Please explain these changes. How, in the context of a program with member months growing rapidly, can Michigan cut back so much on medical review? Similarly, given expected program growth, why will data management costs change so dramatically?

The broad explanation for why administrative costs are declining is that we have moved beyond the development period where investment is greater. This is certainly true of data management costs where data systems infrastructure has been developed. Our view of the ongoing operational costs of these data functions is that the state would be

incurring similar costs in administering fee-for-service programs for this population of 750,000 plus.

Spending on medical on-site review is directly related to the federally mandated External Quality Review (EQR). For years 2000 and 2001, EQR focus studies were designed and conducted to yield plan-to-plan comparative results. This was necessary because at this time, Michigan had little or no data sources available to perform plan-to-plan comparative analysis. Studies designed and conducted to yield plan comparative results require representative samples for each of the plans. For review year 1999, the total records reviewed were in excess of 8000. The medical record review accounts for at least 50% of the total EQR costs.

In the intervening time (2000-2002), MDCH developed and implemented encounter data reporting requirements, and now maintains a robust encounter data warehouse with over 50 million records for the managed care population. In addition, as part of the 2000 contract re-bid process, MDCH established contractual language that requires Medicaid contracted health plans to submit annual audited HEDIS reports and to conduct annual consumer satisfaction surveys. These are administrative costs assumed by the plans.

As a result of obtaining regular encounter data, and valid HEDIS and survey data, MDCH has shifted from the use of EQR data to the use of HEDIS data for achieving objectives related to quality of care and access performance monitoring and improvement that permits plan to plan comparisons. The EQR continues to be a vital component of the MDCH quality assessment program. The EQR is focused on program wide evaluations of clinical and service areas which are not addressed through HEDIS and encounter data sources.

10. Please report on Michigan's compliance with requirements to remove managed care costs from its UPL calculations for institutional providers.

Michigan is in compliance with requirements to remove managed care costs from institutional UPL calculations.

11. Please provide information on how the without waiver spending estimate has or will be adjusted downward to account for transition payments under the UPL for institutional providers.

Transition payments under the UPL for institutional providers have been removed from all of our cost effectiveness analyses.

GENERAL IMPACT:

12. Please provide a list and summary of MDCH's meetings with the four agencies serving persons with physical or mental disabilities described on page 7.

MACIL: MI Association of Centers for Independent Living
MDRC: Michigan Disability Rights Coalition
MRS: Michigan Rehabilitation Services
MDCD: Michigan Department of Career Development

The MDCH has had an informal relationship with the networks described above. There has been informal ongoing sharing of information as changes are made to the program and/or focus of these networks. There is also partnering, communication regarding resolution as issues arise.

Earlier at the inception of the first waiver process, the MDCH met frequently with "Grass Roots" advocacy groups, where MDCH was encouraged to pursue a grant from the Robert Wood Johnson Foundation to address issues around disabilities. The project that developed was a collaboration of the MDCH, the agencies noted above, as well as QHP participants. We have just received the final report of the project and are in the process of reviewing the findings and recommendations. Attached are the Executive summary and Introduction documents to this report, titled, "Supporting the Transition of Medicaid Beneficiaries with Disabilities into Managed Care in Michigan."

13. Now that the State has the authority to implement the rural exception, per CMS, October 23, 2002, approval, please explain why the waiver will not be available throughout the State.

Michigan operates the Comprehensive Health Care Program Waiver statewide. However, automatic assignment of beneficiaries into health plans allowed under the waiver was not available in all counties due to low health plan saturation in certain rural counties. With the approval of the rural exception amendment to the waiver on October 23, 2002, the waiver will be utilized more fully throughout the state because the State may automatically assign eligible beneficiaries into a single approved health plan in a rural county.

DCH plans to implement the rural exception with a phased-in approach. DCH has implemented the exception in the Upper Peninsula of Michigan effective January 1, 2003 and expects to begin workgroup meetings in January for the implementation in certain rural counties in the Northern portion of the Lower Peninsula. The State will not implement the rural exception in all rural counties in the Lower Peninsula. The counties currently being considered for the rural exception include the following: Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Emmet, Grand Traverse, Huron, Iosco, Kalkaska, Leelanau, Montmorency, Presque Isle, and Sanilac.

14. It is appropriate for the State to check item I.1 on page 15, (Excluded Populations) because the State does not currently allow dual eligibles to enroll in the CHCP. When State officials decide to re-enroll this population, the State should submit a waiver amendment that will include a revised page 15, indicating that this population is no longer excluded. The

State should remove the language regarding future potential plans to re-enroll this population via a contract change. Similar references to future enrollment for this population should also be removed.

Delete the explanation under 2 (l)(1), page 15.

15. Please explain why the State's medical exception policy state on page 27 (item j) appears inconsistent with the State's current policy. Please clarify if the State means "the MCO" or "any MCO" in the enrollee's service area at the time of enrollment.

The words "the MCO" should be replaced by "any MCO" (in the enrollee's service area at the time of enrollment) in item 4(i), page 27.

16. Please explain why the State has listed dental and developmental disabilities services in both columns 5 and 6 in the chart on page 34.

Dental should be listed only under column 5, and developmental disabilities services should be listed under column 6 only.

17. Please explain why detoxification inpatient hospital psychiatric services and other mental health services provided by the Community Mental Health Service Programs are listed in column 6 as services that the MCOs in this program impact.

Detoxification should be listed in column 5 only. Mental health services (the first 20 visits) are listed in column 4 as a capitated reimbursement, while mental health services (over 20 visits) is listed under column 5 as a fee-for-service reimbursement impacted by MCO/PHP.

18. Please explain why the state has listed private duty nursing and transportation for non-covered services in column 3 as section 1915(b)(3) services. We note that the State has not indicated a request for a 1915(b)(3) waiver on page 11.

Private duty nursing should be listed in column 5 (not 3) and transportation for non-covered services should not be listed at all.

19. Please address the request on page 41-42, item 7b for a description of the activities that the State will undertake to improve the percentage of EPSDT screens administered for enrollees under the waiver.

Michigan Medicaid managed care plans have many quality improvement activities in place to increase utilization of well child services. These activities include written outreach (e.g., birthday card reminders), telephone outreach, incentives to receive care,

after-hours access, and free transportation. Despite considerable effort, there is still opportunity to improve.

In order to work toward improving utilization of EPSDT and well child services, MDCH partnered with Institute for Health Care Studies (IHCS) at Michigan State University to coordinate collaborative improvement efforts among Medicaid health plans, local health departments, and other community-based providers. Collaborative efforts are focused in three key areas:

- **Beneficiary knowledge**
- **Provider education**
- **Building partnerships**

<u>Beneficiary Knowledge</u>

Michigan State University's Institute for Health Care Studies (IHCS), in collaboration with the Michigan Department of Community Health (MDCH) and the Foundation for Accountability (FACCT), convened and facilitated six focus groups with the parents/guardians of Michigan Medicaid beneficiaries. The primary purpose of the project was to gain insight and knowledge that would drive the design of quality improvement initiatives directed at increasing EPSDT/well child check-up screening rates. The focus group model involved working with small groups of parents/guardians to identify barriers to receiving preventive care and to determine what drives behavior change among these parents/guardians.

The focus groups, which were completed in May 2002, allowed for an in-depth exploration of values, beliefs, attitudes, and practices of urban Medicaid beneficiaries.

The primary purpose of the project was to gain insight and knowledge to drive the design of quality improvement initiatives directed at increasing EPSDT/well child check-up rates for Michigan Medicaid beneficiaries.

Survey questions were designed to:

- **Identify the values, attitudes, and beliefs of parents/guardians about well child care that will encourage them to seek preventive care for their children with increasing frequency and regularity;**
- **Obtain information about the respondents' use of the health care system;**
- **Identify the components of well child check-ups that are valued by respondents;**
- **Identify values, attitudes, and beliefs of parent/guardians regarding which factors are important for maintaining and promoting health in their children;**
- **Identify parents'/guardians' preferred mode and method of communication.**

In summary, the focus group findings suggest that well child check-ups are not utilized primarily due to:

- **Lack of familiarity with the term and concept of "well child check-up";**

- **Lack of knowledge regarding the specific services offered through a "well child check-up";**
- **Assumptions that acute care and follow-up visits are equivalent to a "well child check-up";**
- **Lack of parental focus or value on preventive health care;**
- **Time and energy constraints due to living stressful, busy lives;**
- **Perceived lack of encouragement from health care practitioners to schedule well child visits;**
- **Apparent lack of office system processes to educate and schedule well child visits when chronic or acute care is being provided; and**
- **Inherent differences among segments of the population in knowledge and use of preventive care services.**

MDCH, IHCS, and Medicaid health plans will utilize the findings from the focus groups to review and revise beneficiary outreach and educational material and consider the development of additional innovative beneficiary educational strategies.

Provider education

The Institute for Health Care Studies (IHCS), in collaboration with the Michigan Department of Community Health (MDCH), Michigan Association of Health Plans (MAHP), and Michigan Association of Local Public Health (MALPH), participated in a collaborative monthly workgroup to create and distribute a provider toolkit to facilitate EPSDT education and documentation in provider offices. The toolkit includes age specific Health Maintenance Exam forms to document physical, emotional and developmental findings as well as anticipatory guidance and family resources; a provider pamphlet explaining EPSDT; current immunization information, forms, and codes; and a laminated periodicity table to display in exam rooms.

The toolkit will be distributed on a pilot basis to selected high volume pediatric and family practice offices. This process will allow evaluation of the effectiveness of the toolkit before printing a large volume for distribution.

The pilot process will include the following:

- **Each health plan will identify one high volume pediatric or family practice office.**
- **IHCS will provide a toolkit and a written cover sheet for each office to the health plan.**
- **The health plan will hand carry the toolkit to the chosen provider's office, discuss the contents with the practitioner or office manager, and explain the importance of using the materials contained in the toolkit.**
- **The toolkits will be delivered to the offices by January 31, 2003.**
- **The health plans will provide IHCS with the practitioner/practice's name and address, date of delivery and name of the office contact person after the kits are delivered.**
- **IHCS will follow-up with the contact person 30-60 days after receipt of the toolkit to obtain feedback.**

- **Comments from the pilot offices will be aggregated and shared with the health plans.**
- **The toolkit will be modified as indicated.**

Building Partnerships:

The Institute for Health Care Studies (IHCS), has also in collaboration with MDCH, MAHP, and MALPH, organized and facilitated an interactive forum designed to promote awareness and understanding regarding maternal/child outreach issues. The "Building Bridges" forum aimed to convene local public health and health plan managers to identify opportunities to work together to maximize the value of outreach efforts and funding.

The *goals and purpose of the one-day forum* were to:

- **Facilitate interaction and relationship building between managers in health plans and Local Public Health**
- **Identify each system's role in outreach**
- **Identify common ground and opportunities for outreach partnerships**
- **Collaboratively create solutions/interventions to outreach issues.**

Participants in the June 20 "Building Bridges" forum appreciated the opportunity to network with their colleagues from other agencies and begin to identify solutions to their common issues. Evaluation from the session indicated that the goals of the day were met. More importantly, participants enthusiastically supported the need for additional forums to continue dialogue and improve intra-system collaboration. The dialogue and partnership building will continue when the group reconvenes. Work on the following objectives will continue:

- **Fostering outreach partnerships**
- **Establishing common ground for collaboration**
- **Maximizing and coordinating outreach resources**
- **Establishing mechanisms for system accountability and performance measurement.**

Participants will again be asked to put collaboration into action in small work group discussions. The facilitators of the small work groups will present action plan progress reports as outlined in this report.

Michigan's maternal/child health initiatives will continue to include collaborative partnerships with IHCS, MAHP, and MALPH. IHCS will continue to organize and facilitate the Maternal/Child Health QI Work Group and "Building Bridges" forums.

	2000	2001	2002
Childhood Imm 1	49%	57%	65%
Childhood Imm 2	35%	44%	59%
Adolescent Imm 1	15%	20%	31%
Adolescent Imm 2	6%	7%	12%

20. Please include the requested immunization rates in the state's response to item c on page 43.

STATE AVERAGE IMMUNIZATION RATES FROM HEDIS DATA

This table has been included in item c on page 43 of the waiver.

21. Why are residents of correctional facilities listed in the section regarding excluded populations (item 13, page 16)?

Residents of correctional facilities ARE NOT an excluded population and the reference was taken out of item 13, page 16.

ACCESS AND CAPACITY:

22. How will the State institute measures to determine the clinical impact of coordination with CMHSPs?

The State will institute measures to determine the clinical impact of coordination with CMHSPs through the ongoing efforts of the Clinical Advisory Committee. The actual focus areas and associated measures have not been determined as the committee held its first meeting December 9, 2002. It is expected that as the committee continues to meet and prioritize areas of coordination, the clinical measures will be determined. In general, the development of the measures will involve a review of the literature and evidence based guidelines, selection of specific indicators applicable to the condition/population, and development of a methodology to assess baseline and ongoing performance of both behavioral health and physical health providers with the selected indicators.

- **The Mental Health Advisory Committee (MHAC) is comprised of representatives from:**

  MDCH, including chair
  1 representative from Michigan Association of Health plans (MAHP)
  1 representative from Michigan Association of Community Mental Health Boards
  6 Medicaid Managed Care Organizations (MCOs)
  6 Prepaid Health Plans (PHPs)

- **MCOs and PHPs representing the following geographic areas of the state:**

  West Michigan/Kent county
  City of Detroit/Wayne county
  Upper Peninsula
  Bay/Arenac rural
  Genessee County/North Central
  Mid Michigan

- **Medical Director from each PHP and MCO**

- **Quarterly meetings beginning December 2002**

The purpose of MHAC is to:

- **Establish a process for obtaining ongoing input from stakeholders to identify methods of coordination between MCOs and PHPs and to address coordination issues that arise between these two systems.**

- **Identify areas where coordination is occurring between MCOs and PHPs, and share with both systems through a variety of means, including workshops, training, and formal consultation.**

- **Develop effective measures of clinical coordination by the MCOs and PHPs and a strategy for improving clinical coordination between the two entities.**

23. Please describe how the State adhered to CMS policy regarding the State's public process for seeking comments from Michigan's tribes on the renewal of this waiver.

The State adhered to CMS policy regarding seeking comment from Michigan's tribes during the waiver renewal process. On October 26, 2001, Michigan's Medicaid Director, Robert Smedes, sent a letter to each Indian Health Center requesting input on the State's intent to seek a renewal of the Comprehensive Health Care Program waiver.

24. Please revise the State's answer on page 65, item 10 to indicate that the MCO's are contracting with tribal health providers, rather than the Indian Health Services (HIS). The HIS does not provide direct services in the State of Michigan.

The State's answer to item 10 on page 65 should report that the MCOs contract with tribal health providers. DCH policy refers to tribal health providers as Indian Health Centers (IHC). These IHCs are distinct from Indian Health Services and are direct providers of health services.

25. What action is the State taking to ensure that enrollees are receiving case management services?

The State ensures that enrollees are receiving case management services as part of DCH's on-going site review processes (See Attachment J, Sections 4.3 and 4.10 of the Site Tool). These two criteria on the site review tool specifically address the MCOs' provision of case management services. According to the onsite summary for the October 2001-September 2002 cycle, 94% of the health plans passed on having documented and implemented case management processes for its members. Ninety-five (95%) of the plans had processes in place for case management of the children with special health care needs members as described by the Medicaid Director letters from CMS.

DCH evaluates the MCOs' utilization management program to assess the MCOs' case management of members with complex health care needs. Additionally, DCH requires demonstration that the MCOs' assess members who are identified as children with special health care needs and that treatment plans are developed and implemented, when appropriate. DCH reviews documentation that the CMHSP was involved in the development of the treatment plan, when appropriate.

Case management/coordination of care is also a part of the accreditation standards for both NCQA and JCAHO.

OMNICARE:

26. What characteristics would indicate to CMS that OmniCare and other health plans are no longer meeting the State's solvency criteria?

The State Medicaid agency contracts with Michigan licensed HMOs; therefore Medicaid contracted health plans are subject to all rules and regulations as specified in the Michigan Insurance Code, Act 218 of 1956. Within Michigan Insurance Code, section 3507 authorizes the Insurance Commissioner to regulate health maintenance organizations, including assuring that HMO's are financially sound.

Maintenance of HMO licensure is the primary assurance that the health plan is financially solvent. Licensed HMOs must submit quarterly and annual audited financial statements to the Office of Financial and Insurance Services (OFIS). OFIS performs the financial analysis and review necessary to determine that a health plan is safe, reliable, and entitled to public confidence and therefore, entitled to retain its contract. OFIS has staff that has experience and financial expertise necessary to perform their primary function of insurance regulation. OFIS has access to reports, financial data and other resources from the National Association of Insurance Commissioners (NAIC) that MDCH does not. In summary, although MDCH does monitor the financial condition of its contracted health plans, OFIS performs the in-depth analysis of the financial statements and has the authority to take appropriate regulatory action against a HMO's license.

Until the summer of 2000, Michigan solvency requirements for HMOs were based on the original state statute governing health maintenance organizations enacted in 1974, which had very low capitalization requirements. In June of 2000 significant changes in both the solvency protection and the oversight of HMOs were enacted by the Michigan Legislature and signed into law by Governor Engler. The Michigan Legislature and OFIS realized it would take health plans time to reach the new higher financial requirements especially those plans whose corporate structure is membership based and therefore, have limited access to additional capital. OFIS realized additional funding to meet the new requirements would need to come from health plan operations instead of capital infusions. Therefore, transition periods were contemplated both in the new statute and in application.

The Medicaid Contract requires plans to meet the HMO requirements covered by Statute, including all of the financial requirements. Some of the new requirements are not effective until December 31, 2003 for any health plan licensed as an HMO prior to the passage of the new statute. The specific statutory requirement that has a phase-in provision is:

Net Worth Requirements:
Minimum net worth is greatest of the following (if the HMO provides a network sufficient to provide 90% of HMO benefit payout):

- **$1,500,000**
- **Four Percent of the HMO's subscription revenue**
- **Three Months uncovered expenditures**

Minimum net worth is greatest of following (if the HMO does not provides a network sufficient to provide 90 % of the HMO' s benefit payout):

- **$3,000,000**
- **Ten Percent of the HMOs subscription revenue**
- **Three months uncovered expenditures**

The above new requirement takes effect on December 31, 2003 or at the time an HMO attains a level of net worth as identified above—at which time the HMO is required to continue to maintain that level of net worth. Therefore, some HMOs may still have requirements under the previous statute, which included an initial funding standard of $100,000 for net worth.

Licensed HMOs provide quarterly financial statements to OFIS and provide MDCH with a copy of the same financial statements for our files. HMO's are further subject to financial audits by OFIS. An actuary must certify their claim liabilities, and their bids must be certified as actuarially sound in order to qualify as an acceptable proposal. The assessment and interpretation of all financial statements is performed by OFIS, as required by the Michigan law.

Plans that do not meet the standards, including negative working capital, are expected by OFIS to establish plans to come into compliance within timeframes as approved and monitored by OFIS. OFIS has the responsibility of tracking performance in this area, including application of remedies under state law including Supervision and Rehabilitation. If an HMO becomes insolvent, the commissioner shall inform the state agency responsible for the program of the insolvency. The HMO has an independent duty to inform MDCH.

27. How will the state provide CMS with ongoing information regarding OmniCare's financial status?

Licensed HMOs provide quarterly financial statements to OFIS and provide MDCH with a copy of the same financial statements for our files. Upon receipt, MDCH will provide CMS with copies of OmniCare's quarterly financial statements.

All quarterly HMO financial statements are posted on the OFIS web site at http://www.michigan.gov/cis under HMO Financial Information. For example, the third quarter financial statement for OmniCare may be found at http://www.michigan.gov/documents/cis_ofis_2002_3q_50764_7.pdf.